California Board of
PSYCHOLOGY

1625 North Market Blvd., Suite N-215, Sacramento, CA 95834
T (916) 574-7720 F (916) 574-8672 Toll-Free (866) 503-3221
www.psychology.ca.gov

# MEMORANDUM

| | |
|---|---|
| **DATE** | May 5, 2016 |
| **TO** | Board Members |
| **FROM** | Antonette Sorrick<br>Executive Officer |
| **SUBJECT** | **Telepsychology Committee Report and Consideration of Committee Recommendations: Agenda Item 28** |

**Background:**

Attached are the following documents:
1) Proposed Additions to CCR Title 16 to Address Standards of Practice for Telehealth
2) Review of Public Comment by Adam Alban, PhD

**Action Requested:**

Review draft regulatory language and move to accept the language as written and proceed with a rulemaking file.

§XXXX Standards of Practice for Telehealth

a) A licensee may provide psychological services via telehealth, as defined in section 2290.5 of the Code, pursuant to the following conditions.

1) The provider of psychological services via telehealth to a resident of California shall hold a valid and current license with the Board.
2) Informed consent for the provision of psychological services via telehealth has been obtained and documented by the licensee. Such consent shall cover concerns unique to the receipt of psychological services via telehealth, including risks to confidentiality and security, data storage policies and procedures specific to telehealth, the possibility of disruption and/or interruption of service due to technological failure, and any other issues that the licensee can reasonably anticipate regarding the non-comparability between psychological services delivered in person and those delivered via telehealth.
3) The delivery of psychological services via telehealth is appropriate. To determine appropriateness, the licensee shall consider the following:
    a. The service recipient's diagnosis, symptoms, and medical/psychological history;
    b. The service recipient's preference for receiving services via telehealth;
    c. The nature of the services to be provided, including anticipated benefits, risks, and constraints resulting from their delivery via telehealth;
    d. Any benefits, risks, or constraints posed by the service recipient's physical location. These include the availability of appropriate physical space for the receipt of psychological services via telehealth, accessibility of local emergency psychological services, and other considerations related to the service recipient's diagnosis, symptoms, or condition.
4) The licensee is competent to deliver psychological services via telehealth. To determine competence, the licensee shall assess whether he or she possesses the appropriate knowledge, skills, and abilities relating to delivery of psychological services via telehealth. This assessment shall include how such services might differ from those delivered in person, and whether he or she has the knowledge, skills and abilities relating to the information technology chosen for the delivery of telehealth services.
5) The licensee takes reasonable steps to ensure that electronic data is transmitted securely, and informs the service recipient immediately of any known data breach or unauthorized dissemination of data.

b) Failure to comply with these regulations shall be considered unprofessional conduct. Providers of telehealth shall comply with all standards set forth by the Board.

Adam D. Alban, Ph.D., J.D.
Attorney at Law
Clinical Psychologist

415-350-0106
alban@clinicallawyer.com

www.clinicallawyer.com
SBN 248546 PSY 21568

February 25th, 2016

Dear Members of the Board,

Thank you for the opportunity to provide commentary on the proposed "Standards of Practice for Telehealth" regulation. It is an excellent start to a difficult and fast-moving regulatory dilemma: how to regulate the provision of mental health services via medium that were not envisioned just 15 years ago.

I regret that I am not able to attend the February 26th, 2016 Board meeting, but I had pre-existing flight reservations that could not be altered. Thus, I am providing this commentary as a hand-carry item.

I have some experience in this area that I believe may be helpful. In addition to being a California licensed psychologist and attorney admitted to practice in California, I frequently advise clients on elements of HIPAA and the use of technology in clinical practice. Some years ago when clients were asking increasingly technical questions about how to responsibly use apps and the internet in clinical practice, I decided that the best way to advise clients would be to build and launch an app of my own. What better way to learn than by doing? The app that was ultimately launched in 2014 remains one of the only notetaking products designed for mental health professionals and is currently used worldwide.

Since that time I have also been an outside advisory counsel for several existing telehealth companies, as well as startup ventures that aim to address the issue of how to provide mental health services on a large-scale via technologies that are currently in existence, or are currently under development. These companies aim to provide mental health and/or substance abuse treatment via laptop/desktop computer, smartphone application, and other means. Some wish to craft individual treatment plans not-unlike traditional psychotherapies, whereas others aim to automate treatment via computer algorithm and provide human contact only intermittently.

It is clear that, insofar as economics are concerned, behavioral health is seen by the business community as one of the most attractive health services. Behavioral health treatment, as a general matter, requires less equipment, fewer lab reports, and less physical infrastructure. The professionals are also, relatively speaking, less costly. Compared to other health disciplines, mental health treatment is also more scalable and easier to provide via remote. Thus, it is an attractive economic opportunity.

I mention this so that the Board is aware of the nature of what is on the horizon. The nature of telehealth is rapidly expanding beyond therapy via telephone or webcam and is driven by economic incentives. This is a tricky regulatory dilemma, especially given that regulations considered now will not become active for months, if not years. There are no "right" answers.

The Board's mandate is to protect the public, and to that end I believe that when the Board is drafting regulations for such a rapidly changing environment the Board should consider the following additional questions:

1.) To what extent should the Board leave regulations open-ended in order to remain relevant and applicable for emerging technologies?

The challenge of regulating emerging technologies is that the technology changes faster than regulations. Thus, regulatory bodies are faced with the dilemma of how to draft rules that are specific enough to protect the public and provide practical guidance to the regulated population, yet not so specific as to become obsolete and irrelevant when technology changes.

Having said that, it may be helpful for the Board to consider adding language to these proposed standards of practice (or elsewhere) that contemplates at least two additional subjects: supervision and automated services.

With respect to supervision, the my understanding is that the Board's current interpretation of the 16 CCR 1387(a)(4) requirement for one hour per week of face-to-face direct individual supervision with a primary supervisor does not allow face-to-face and direct supervision via video chat or other distance technology. Reasonable psychologists can and do disagree on whether supervision by video is equivalent, and in many ways this is an empirical question. However, this may be an opportune time for the Board to address this issue and provide more clarity to the regulated profession.

With respect to automated services, an emerging dilemma for psychologists is at which point the psychologist-patient relationship begins. Do these regulations speak to a situation where a consumer is receiving automated services, such as via a standardized curriculum on the internet or via app, but receiving direct services from a licensed individual only periodically or after a symptom threshold has been reached? Is the provision of telehealth services via automation regulated under this rule? Does this proposed rule only apply to the services provided directly by a psychologist and not to the automated services? In either case, it may be prudent to address such a scenario at least in general terms.

2.) Given that telehealth is and changing expanding rapidly, to what extent should "standards of practice" yield to empirical data on efficacy?

It would be useful to add a provision to (a)(3)(e?) that allows for the "appropriate" delivery of psychological services via telehealth where empirical support or some other external criterion suggests that such an intervention is appropriate. This is a complex issue but given that, as currently drafted, subsection (b) states that failure "shall be considered

unprofessional conduct," it could stifle the provision of new effective services if the Board restricted the definition of "appropriate" to that which is described in (a)(3)(a-d). In any event, some additional flexibility is likely warranted.

3.) Given the Board's legislative mandate to regulate the practice of psychology, to what extent does the Board wish to expand its traditional enforcement practices away from regulating psychologists and toward regulating psychological practice?

As new technologies make the provision of telehealth services more viable and available to a broader spectrum of California consumers, this is a good time to reevaluate and possibly reconsider the Board's historic stance on enforcement matters with respect to persons and entities that are not psychologists or registrants.

Historically, and as a general matter (though there are some exceptions) the Board's enforcement staff has declined to take action or investigate complaints against parties who are not California licensed psychologists or subject to registration with the Board. In effect, the practical outcome of this has been that the Board regulates California psychologists, not psychology.

By way of example, several years ago the Board of Psychology's enforcement staff was made aware, via multiple complaints, of a troublesome business in Southern California where a non-psychiatrist physician was operating and advertising a business as a psychology practice. This was a physician who had no training in mental health, and who was operating a workers comp psychological evaluation and treatment practice. This "psychology" clinic was performing intakes on huge numbers of new patients and then assigning the care of those patients to small numbers of contracted psychologists, none of whom could cope with massive caseloads of hundreds of patients per psychologist. Patients had acute symptoms and they were not receiving the attention or care that was needed and promised. The result was a revolving door of contract psychologists who were hired and then who quickly resigned because they could not provide adequate care. The public was clearly at risk.

When alerted to the issue the Board of Psychology's enforcement staff indicated that because the alleged offenders were not psychologists the Board of Psychology would not take action. The Board referred the concerned parties to the California Medical Board, which in turn declined to take action because the allegations concerned the practice of psychology, which was outside the purview of Medical Board. Thus, despite the clear danger to the public this clinic remained in operation until January 2016 when it was ultimately shut down by the state of San Diego District Attorney's office and the FBI amid allegations that it amounted to one of the largest fraudulent kickback schemes ever uncovered in San Diego County.

The point of this example is not to point fingers at the Board of Psychology's enforcement staff, but rather to articulate the gap between the Board's legislative mandate to regulate the practice of psychology and the Board's apparent practice of largely restricting those enforcement activities to psychologists and registrants. As stated above, the practical outcome is that the Board regulates psychologists, not psychology.

This is presently concerning but threatens to become a much larger problem if entities providing telehealth psychological services to California residents remain largely unchecked. Telehealth enables the provision of psychological services on a massive scale. Without clarity on (1) the Board's enforcement stance toward unlicensed/unregistered persons or entities, and/or (2) guidance on when automated services become "practice" the issue could become much more complex.

Furthermore, if the Board remains reluctant to regulate entities/persons who are not psychologists/registrants, the problem could become compounded by the reluctance of psychologists to provide guidance to businesses for fear that the spotlight of enforcement would suddenly shine on psychologists who are attempting to fix services. This is what happened in the aforementioned San Diego County workers comp kickback scheme, to wit, that the Board's refusal to investigate non-psychologists had the perverse effect of discouraging psychologists from intervening and providing any services, lest they become the only parties subject to regulatory oversight. The Board should consider whether its reluctance to regulate non-psychologists results in a disincentive for responsible psychologists to attempt to assist patients in the midst of business models that favor volume over clinical care.

It appears prudent for the Board to consider a multistep solution that broadens the scope of its enforcement activities while simultaneously encouraging the involvement of psychologists in telehealth psychological services via technological oversight and direct clinical care. Psychologists have an important role to play in these emerging technologies and can provide valuable services to the public. The Board could consider, for example, an additional provision that requires psychologists or similarly licensed professionals to oversee/supervise psychological services provided via telehealth. Alternatively, the same result could be achieved by enforcing laws restricting and regulating the practice of psychology against individuals/entities who are not psychologists or registrants.

I am available to discuss these matters with the Board, and I hope that the discussion will expand to cover a variety of perspectives that are different from mine. My thoughts on these matters have evolved over these last few years and I expect that they will continue to do so. But most importantly, the public and the profession are likely to benefit when we can simultaneously embrace different perspectives and encourage responsible practice. This is truly a case where a heterogeneity of ideas and perspectives benefit all.

Sincerely,

Adam Alban, Ph.D., J.D.